

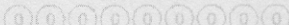






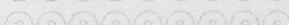


NAME (LAST, FIRST, MI)		GRADE		SSN		DO NOT WRITE IN THIS SPACE 100001 
DATE (DDMMYYYY)	DEPLOYING UNIT					
DOB (DD-MM-YYYY)	UIC	MOS				
MOBILIZATION DATE (DD-MM-YYYY)		MOBILIZATION STATION (SRP SITE)				
OPERATION						
COMPONENT	ACTIVE	RESERVE	GUARD			
HOME PHONE						
HOME OF RECORD (ADDRESS)						
						
						

COMPLETE PARTS 1 AND 2, MARK EACH ANSWER THAT APPLIES

1. DEPLOYMENT	DEPLOYMENT LOCATIONS	LIST OTHER DEPLOYMENT LOCATIONS IN THIS BOX
<input type="radio"/> CONUS <input type="radio"/> OCONUS	<input type="radio"/> IRAQ <input type="radio"/> EUROPE <input type="radio"/> AFGHANISTAN <input type="radio"/> OTHER	

2. DID YOU HAVE INJURIES FROM ANY OF THE FOLLOWING WHILE YOU WERE DEPLOYED?
(IF YES, INDICATE THE NUMBER EPISODES TO THE RIGHT OF EACH CAUSE.)

			NUMBER OF EPISODES							
	YES	NO				1	2	3	4	5 OR MORE
A. FRAGMENT	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. BULLETS	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. VEHICULAR	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. BLAST (ANY)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. FALL	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F. DATE OF MOST SERIOUS INJURY (DDMMYYYY) .

IF YOU DID NOT REPORT ANY INJURIES IN PART 2, STOP AND DO NOT COMPLETE PARTS 3 AND 4 BELOW.

3. DID ANY OF THE INJURIES YOU RECEIVED WHILE DEPLOYED RESULT IN ANY OF THE FOLLOWING?		
	YES	NO
A. BEING DAZED, CONFUSED, OR SEEING STARS	<input checked="" type="radio"/>	<input type="radio"/>
B. NOT REMEMBERING THE INJURY	<input type="radio"/>	<input type="radio"/>
C. LOSS OF CONSCIOUSNESS FOR LESS THAN A MINUTE	<input type="radio"/>	<input type="radio"/>
D. LOSS OF CONSCIOUSNESS FOR 1 TO 20 MINUTES	<input type="radio"/>	<input type="radio"/>
E. LOSS OF CONSCIOUSNESS FOR MORE THAN 20 MINUTES	<input type="radio"/>	<input type="radio"/>
F. SYMPTOMS OF CONCUSSION	<input type="radio"/>	<input type="radio"/>
G. HEAD INJURY	<input type="radio"/>	<input type="radio"/>
H. NONE OF THE ABOVE	<input type="radio"/>	<input type="radio"/>

4. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS FROM INJURIES NOTED IN PART #2? (IF NO, LEAVE BLANK. IF YES, INDICATE BELOW WHEN YOU HAD THE SYMPTOM.)				MARK THE CIRCLES BELOW FOR EACH SYMPTOM THAT WAS A <u>PROBLEM BEFORE</u> YOUR INJURIES.		FOR EACH SYMPTOM THAT <u>WAS A PROBLEM BEFORE</u> YOUR INJURIES, MARK THE CIRCLES BELOW IF IT <u>WORSENERD AFTER</u> YOUR INJURIES.	
	RIGHT AFTER INJURY	NOW					
A. HEADACHE	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
B. DIZZINESS	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
C. MEMORY PROBLEMS	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
D. BALANCE PROBLEMS	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
E. RINGING IN EARS	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
F. IRRITABILITY	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
G. SLEEP PROBLEMS	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	
H. OTHER, SPECIFY BELOW	<input type="radio"/>	<input type="radio"/>	▶	▶	<input type="radio"/>	<input type="radio"/>	

SRP FORT CARSON TBI QUESTIONNAIRE

THIS PAGE FOR USE BY MEDICAL REVIEWER ONLY

DO NOT WRITE IN
THIS SPACE
100001

5. REFERRAL

	PREVIOUS	INDICATED
A. NONE	<input type="radio"/>	<input type="radio"/>
B. EDUCATION	<input type="radio"/>	<input type="radio"/>
C. PSYCH LEVEL 2	<input type="radio"/>	<input type="radio"/>
D. PSYCH LEVEL 3	<input type="radio"/>	<input type="radio"/>
E. PRIM CARE	<input type="radio"/>	<input type="radio"/>
F. NEURO	<input type="radio"/>	<input type="radio"/>
G. NEUROPSYCH	<input type="radio"/>	<input type="radio"/>
H. EENT	<input type="radio"/>	<input type="radio"/>
I. NEUROSURG	<input type="radio"/>	<input type="radio"/>
J. OTHER, SPECIFY BELOW	<input type="radio"/>	<input type="radio"/>

6. DATABASE FOR FOLLOW-UP

☐ PROB TBI - ASYMPTOMATIC F/U 90D

☐ PROB TBI - CURRENT SYMPTOMS

☐ NO TBI

COMMENTS

REVIEWER SIGNATURE

DATE

AUTHORITY FOR COLLECTION OF INFORMATION: Sections 133, 107-187, 3017, 5031, and 8012, title 10 US Code and Exec Order 9397

PURPOSE: To facilitate health care and identify medical records

ROUTINE USES: To plan, provide, and coordinate health care. To document post deployment health concerns, aid in preventive health, compile statistical data, and evaluate the scope and quality of care.

DISCLOSURE: Mandatory for all military personnel. Voluntary for all other personnel. If the requested information is not provided, comprehensive health care may not be possible, but care will not be denied.

REV: 24 JUN 2005